Approved Date: 11/14/2007

CRITERIA FOR PRIOR AUTHORIZATION

Appropriate NDC
(Item or Procedure Here)

Selzentry® (maraviroc)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug requires prior authorization: Selzentry® (maraviroc)

CRITERIA: (must meet the following)

1. Prior authorization may be approved when the following applies:
    a. Patient is infected with only CCR5-tropic HIV – 1 (R5 HIV -1) detectable strain, who have evidence of viral replication, and HIV – 1 strains resistant to multiple antiretroviral agents as determined by tropism testing and treatment history.
    b. Patient is not infected with dual/mixed and/or CXCR4-tropic HIV -1.
    c. Patient must be 16 years of age or older.
    d. Patient must be treatment experienced.

OR

2. Previously enrolled in the Pfizer Expanded Access Program.

AND

3. Prescribed by an HIV specialist.

Prior Authorization will be approved for one year.

Criteria (and revisions) recommended by the Drug Utilization Review Committee